Michigan Association of Health Plans

H.B. 4875 and 4877
House Committee on Health Policy

October 1, 2013

My name is Christine Shearer and I am the Deputy Director of the Office of Legislation and Advocacy for the Michigan Association of Health Plans. Our association represents 15 health plans serving over 2.5 Michigan citizens in Medicaid, Medicare and Commercial products and 55 business and limited members. Members of MAHP employ nearly 4000 individuals throughout Michigan. With me today is Fran Wallace, from FKW Consulting to assist with any questions.

MAHP is opposed to these bills for two reasons. First, these bills are unnecessary because provisions of the Affordable Care Act (or ACA) provide better protection for enrollees by establishing an upper limit on the total amount of cost-sharing an individual must pay for health care in one year, rather than providing separate limits on copayments, coinsurance and deductibles. And second, the language with respect to copayments and deductibles would create confusion for both enrollees and providers.

Each of these three bills applies to different types of insurers or health plans. HB 4875 applies to insurers and health maintenance organizations; HB 4876 applies to health care corporations (Blues Cross) and HB 4877 applies to third party administrators.

To help keep my testimony clear, I'll refer to health plans as the entity subject to the terms of the bills, and the enrollee as the individual subject to the relevant cost-sharing. I will be limiting my comments to HB's 4875 and 4877 as these two that affect our members.

Copayments and Coinsurance

Subsection (1)(A) of the bills limits copayments and coinsurance to no more than 50% of the cost of the health care service. To clarify, *a copayment is the flat dollar amount and coinsurance is the percentage amount paid by an enrollee for a particular health care service.* The problem with this provision relates to copayments.

Section 3515(2) of the HMO chapter in the Michigan Insurance Code currently limits the amount of coinsurance an enrollee will pay to 50% of the cost of the health care service, excluding deductibles. This provision used to limit copayments to "nominal" or 50% of the cost of the service, as well, but this provision was amended several years ago to eliminate the restriction on copayments. This change was made for two reasons: Employers purchase benefit plans expecting copayments to be applied as the plan dictates, and enrollees and providers were confused when the flat dollar amount they expected was changed after a claim was processed. Employers with employees in multiple states were particularly concerned about Michigan's unique law because it meant employees in different states were often charged different copayments for the same service or prescription.

Applying a 50% limit to copayments requires a separate calculation for services that cost less than double the amount of the copayment. For example, if the service costs $60 and the copayment is $35, the enrollee's copayment would be changed to $30. This makes it more difficult for a provider's office to collect the correct copayment at the time of service, often requiring a refund to be calculated after the office is paid by the health plan. A 50% copayment limit also causes problems with prescription drug copayments. Employers generally choose a benefit plan that sets different copayments for brand and generic drugs, such as $10 for generics and $40 for brands. If a generic prescription costs $15 – the copayment charged would be $7.50, not the $10 that the benefit plan requires. This recalculation leads to confusion for both enrollees and providers.

The current 50% limit on coinsurance only applies to HMOs, not to insurers, Blue Cross or third party administrators.

Under the ACA and the implementation of the Insurance Exchange, it is unlikely that a benefit plan would have a coinsurance amount greater than 50%. The ACA sets limits for small group and individual plans based on the total amount to be paid by the enrollee, including deductibles, copayments and coinsurance.

Further, under the Insurance Exchange, there are several types of plans required to be offered to small groups and individuals. The least generous plan, a so-called Bronze plan, requires an enrollee to pay no more than approximately 40% of the total cost of health care services. Silver plans have a maximum cost-share of approximately 30%; Gold plans, 20%; and Platinum plans, 10%.

All plans offered to small groups and individuals must offer required Essential Health Benefits, which are standard for these so-called metal plans. The maximum amount paid by the consumer for these benefits is the Out of Pocket Maximum, or OOP, which is based on the OOP limits for high deductible plans under health savings accounts – an amount set annually by the IRS. Plans offered by different carriers may have varying coinsurance, copayment and deductible amounts, but the total OOP cannot exceed a predetermined amount.

For individuals and families with income less than 250% of the federal poverty limit, the OOP maximum will be reduced, resulting in even lower cost-sharing amounts.

Large groups are not restricted to offering the defined Essential Health Benefits, however, large employers may face financial penalties if they do not offer minimum essential coverage at a cost that is no more than 40% of the health care services to the enrollee.

Because the ACA limits cost-sharing by looking at the total OOP to be paid by the enrollee, enrollees are protected against excessive cost-sharing. If Michigan enacts different standards for cost-sharing, it will result in confusion for employers and insurers.

Deductibles

Subsection (1)(B)(i) of each bill states that deductibles cannot be established in a way that results in "de minimis reimbursement" being paid to the provider by the health plan. This provision defeats the purpose of a deductible. A deductible is the amount that an enrollee must pay before the health plan pays anything toward the health care service (excluding preventive services, which are not subject to a deductible). If a consumer's deductible is $2,000, for example, the health plan will not pay anything toward a covered health care service until the deductible has been met. This may properly result in no payment or a "de minimis" payment to the provider for a particular service.

Subsection (B)(i) is inconsistent with current health insurance standards. Most health plans have a deductible because deductibles discourage wasteful spending on unnecessary health care services. This provision would have the effect of eliminating deductibles as a cost-sharing mechanism.

Subsection (1)(B)(ii) of each bill states that a deductible amount cannot be applied to a health care service that the health plan reasonably knows will not be met by at least 80% of enrollees. How does a health plan "reasonably know" this? Which 80% of enrollees are counted? Enrollees in a particular employer group or the total number of enrollees covered by the insurer? As written, this requirement would be impossible to comply with.

Conclusion

As I've already stated, the ACA looks at consumer cost-sharing by combining the total amounts of the deductible, copayments and coinsurance to reach an expected OOP maximum. The deductible is just one piece of the total OOP. Plans will be offered with lower deductibles, but they will likely have higher coinsurance percentages and flat dollar copayments. Plans that have higher deductibles will likely have lower coinsurance percentages and flat dollar copayments. An individual enrollee may prefer one or the other, and so may elect the plan he or she prefers. And, in each case, the total OOP will put a cap on the amount the enrollee will pay for health care services annually.

Subsection (1)(B) would lead to confusion and administrative headaches for both health plans and enrollees, because of the different approach to cost-sharing under the ACA. An additional cost-sharing protection under ACA is the requirement that health plans provide a written Summary of Benefits and Coverage to enrollees at the time of enrollment. This summary clearly shows the amount of coinsurance and copayments for each health care service and when any applicable deductible applies.

For all of the above reasons, we believe these bills are unnecessary, would lead to enrollee and provider confusion and would create administrative burdens on health plans. We encourage this committee to vote in opposition to these bills. We would be happy to answer any questions members may have.